DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 7 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2588

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 65

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Dunklin
(b) City or town: Kennett
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Presnell Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 hrs (Specify whether years, months or days)
In this community: 4 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Dunklin 35
(c) City or town: Kennett 2
(If outside city or town limits, write "RURAL")
(d) Street No.: 106 Kennett St. 2
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William Lee Halbrook
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Lucy Halbrook
6. (c) Age of husband or wife if alive: 39 years
7. Birth date of deceased: Feb (Month) 12 (Day) 1903 (Year)

8. AGE: Years 42 Months 11 Days 5 If less than one day hr. min.

9. Birthplace: Greenville (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: Farming

FATHER
12. Name: William Holbrook
13. Birthplace: Unknown (City, town, or county) W. Va. (State or foreign country)

MOTHER
14. Maiden name: Martha Brown
15. Birthplace: Unknown (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Lena Halbrook
(b) Address: 106 Kennett St. Kennett Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-18-1946 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Ridge Cem
18. (a) Signature of funeral director: Lamb Funeral Co
(b) Address: Kennett Mo.
19. (a) 1-17-1946 (Date received by local registrar) (b) Carl Husband (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17 th year 1946 hour 2 minute 00 p. M.
21. I hereby certify that I attended the deceased from 1-17, 1946 to 1-17, 1946 that I last saw him alive on 1-17, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis
Far Advanced
Due to: Bilateral
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy:

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: G. R. Presnell (M. D. or other) M.D.
Address: Kennett Mo Date signed 1-17-46

90 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 246-171
Date Filed 2-5-46

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
1—3-45
P I X43880

536 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Det

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 65

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Kennett
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William L. Halbrook

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 12 1905
(Month) (Day) (Year)

8. AGE: Years 42 Months 11 Days 5 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan 17
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Pulmonary Tuberculosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature G. R. Presnell. MD (M.D. or other)

Address Date signed 2-13-46

2588